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VETERANS BUREAU

By authorization of the House of Delegates a Veterans Bureau will be operated in conjunction with the executive office of the Society to furnish information and service to Rhode Island physicians returning from the armed forces. Every veteran-doctor is urged to communicate with the Society office immediately upon his return to the State, or by mail in advance of his return, to make known his needs for re-establishing his private practice. Information relative to residencies, refresher courses, and other postgraduate information, as well as data relative to procedures for acquiring surplus property for professional offices, locations for private practice and similar matters will be available.

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THE RHODE ISLAND DENTAL SOCIETY
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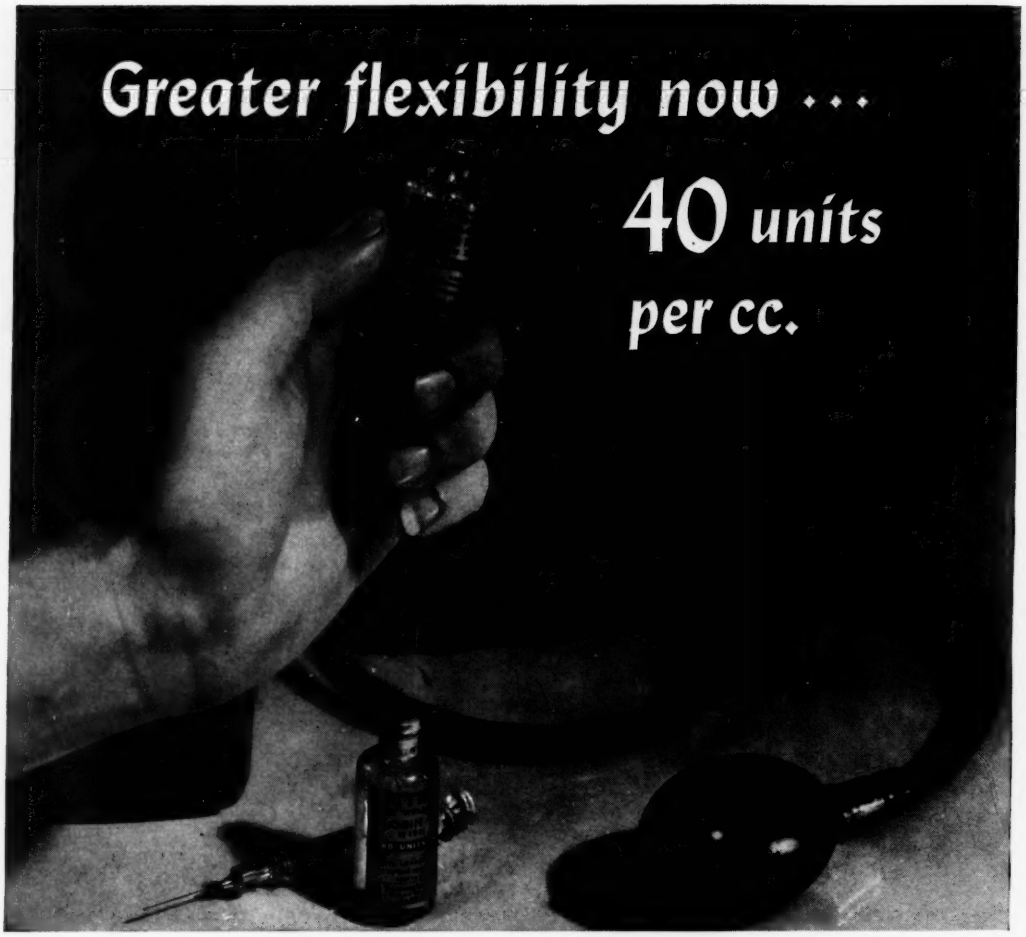

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The RHODE ISLAND MEDICAL JOURNAL

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HUGH OWEN THOMAS — AN APOSTLE OF REST*

ROLAND HAMMOND, M.D.

The Author. *Roland Hammond, M.D., of Providence. Former President of the Providence Medical Association, and of the Rhode Island Medical Society.*

ONE of the most cherished traditions of North Wales is centered about the bone-setters of Anglesea. This island off the Welsh coast, jutting into the Irish Sea, is a district least accessible to modern progress and ideas. It was the country of the Druids, and their descendants the bards. Here priest and leech continued the ancient association of religion and medicine into recent times, until discredited by the medical profession.

Throughout the eighteenth century the Thomas family practiced bone-setting in the community of Anglesea, North Wales. As well-to-do yeoman farmers they could afford to attend to their neighbors' injuries, along with those of the farm animals, without fee and for the general good. As a family they were persons of dominating character, rather ponderous dignity, and endowed with a sardonic sense of humor. One of the family, having fallen out with an acquaintance, shook his late friend's hand, and, it is said dislocated every finger: then while his victim howled in agony, carefully put them right again. At least seven generations of bone setters are recorded in the Thomas family. This peculiar talent has persisted in certain families, and it is a question whether it is to be explained as an inherited gift, or as the result of accumulated observation and experience together with training and opportunity.

There is a legend, well attested by fact, that about two hundred years ago, a boy from Spain was washed ashore from a shipwreck off the coast of Anglesea. He was adopted by the Thomas family and became the ancestor of a long line of bone-setters. The family were devoutly religious, ardent supporters of the Welsh Calvinistic Methodist church, and with a deep sense of public responsibility. No less than twenty-one descendants of this ancestor practiced the family calling and their standing in the community is affirmed by the number of church memorials, sonnets and elegies composed in their memory.

Evan Thomas, the father of Hugh, decided to launch out for himself and, at the age of 19, went to Liverpool, where he attained a remarkable success as a club doctor for workmens associations, and in the general practice of bone-setting. He was anxious to work harmoniously with the medical profession, but he had numerous conflicts with regular practitioners until a suit for malpractice overtook him. He was acquited by a jury after a few moment's deliberation, and was given a public banquet in which he was vindicated in the minds of the responsible citizens of Liverpool. On his retirement from practice in 1863 he was presented with a portrait of himself, a silver tea and coffee service and an illuminated address by the people of Liverpool. Nevertheless, Evan Thomas saw the handwriting on the wall, and after the passage of the Medical Register Act of 1858 he decided that his five sons should become qualified practitioners, and they were entered in the Medical School at Edinburgh University.

Hugh Owen, the eldest son, was born August 23, 1834. He was a delicate child, and his frail physique was a source of care throughout his life. This fact accounted for many of his habits, and explained his apparent eccentricities of dress.

The first great influence of his childhood was that of his mother, a very devout and intellectual woman, who educated him in the habits of good reading and clear thinking. Her influence remained with him all through his life, and after her death, he made a pilgrimage to her grave three times each year.

The second early influence was his kindly thoughtful schoolmaster, an old fashioned village dominie, who recognized that in Thomas burned the divine fire. The boy eagerly absorbed a love for books and nature, and many years later, when the master had fallen on hard times, Thomas assisted him liberally. At school he was struck by a stone below the left eye. This caused a scar and

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*Presented at the meeting of the Providence Medical Association, at Providence, May 7, 1945.

a painful permanent ectropion. To protect the eye from cold winds and to hide the deformity, he began to wear the peculiar peaked cap which became a part of him.

At seventeen he was apprenticed to his maternal uncle, Dr. Owen Roberts of St. Asaph, and here he was fortunate in his mentor. Dr. Roberts was a remarkable student, a friend of Sir Benjamin Brodie, and of Sir Morell Mackenzie, and took a keen interest in the boy's progress.

At the age of twenty-one he entered the University of Edinburgh, and immediately came under the influence of a remarkable group of teachers. Lister was dresser to Syme, and other chairs were filled by Spence, Simpson, Goodsir, Bennett and Turner. At Edinburgh, Thomas was impressed by the frequency with which amputation was performed for inflammation and disease of joints. In his father's practice he had seen these cases treated conservatively with apparently complete success, and already the conviction was strong in his mind that such wholesale amputations were unnecessary and could be avoided if conservative treatment were started early and carried out intelligently.

He returned to assist his father in Great Crosshall Street. Hugh realized that his father's reputation was based on his skill in handling injuries of long standing, and that his treatment of fractures of the lower limb was far in advance of what he had learned at Medical School. The object of all treatment was the restoration of symmetry. In the case of old dislocations this was accomplished by means of a slow, gradual pull with counter pressure and without anesthesia.

The following record from Thomas' Case Book of 1857 is an amazing story:

Dislocation of head of Humerus into Axilla.
Name: Gustavus Wilhelm Georg Vollersen
Profession: Mate of Condor — Hamburg — Peruvian Barque
Country: Schleswig — Holstein
Accident: Off Cape of Good Hope
Time: January 29, 1857, 12 o'clock noon
Reduced: October 31, 1857.
Aid at first trials — seven men
Last trial — ten men.

Reading between the lines we find that the mate fell from the rigging while taking in sail, and dislocated his shoulder. The Captain made an attempt to reduce but unsuccessfully. At Singapore two men-of-war surgeons gave it up. Some Indians tried, after repeated blows along the spine to render him unconscious, but failed. In Liverpool the treatment was as follows: A poultice of warm bran was applied for three days. Then gradual extension over the knee of the operator every other day for fourteen days, each extension being performed for a quarter of an hour by four heavy men. The operation was next performed over a pole which finally broke. The axilla sloughed but was healed in two weeks. The trial was repeated with ten heavy strong men and the pole broke again. Manipulation was continued over the knee for another hour by six men, and then symmetry was complete.

Only a man who had a high reputation for serving the people among whom he lived could have gone out into the Dockland of Liverpool to collect carters to assist him.

The partnership between father and son lasted only about two years and Hugh started an independent practice at 34 Hardy Street, and seven years later, in 1866, he removed to 11 Nelson Street. This house has been the Mecca and also the shrine of orthopaedic surgeons the world over, since Sir Robert Jones practiced there later and it was the office of his asociate Mr. T. P. McMurray, until it was destroyed by a German bomb.

The disagreement with his father seemed to color Hugh's outlook on the activities of unqualified bone-setters. He expressed his opinion of them in no uncertain terms as follows: "My opportunities of observation have not been limited to watching the method of one unqualified practitioner of surgery, but of many, the majority of whom had possessed a widely popular reputation. My contention is this, that in the practice of bone-setting nothing is to be found that can add to our present knowledge. That some of the bone-setters who practiced in past time were in some few special matters superior to their qualified contemporaries, I know to be a fact, but this assertion does not apply to their general knowledge or practice. Concerning diseases of joints I have never met with the slightest evidence that any of them had the slightest knowledge of the subject or a method of treatment which was not utterly wrong."

This association with the old bone-setters was not an auspicious beginning in practice for the young qualified surgeon, who received no countenance from the leaders of the profession in Liverpool at the time. It is little wonder that Thomas became a recluse wholly devoted to his practice, visiting his patients in their slum homes five times a day if they were seriously ill, spending his spare time at his lathes in his workshop devising splints.

After removing to 11 Nelson Street, Thomas built on an annex designed like the out-patient department of a small hospital, with small examining rooms, waiting rooms, a photographic studio, and a blacksmith's shop fitted with every possible tool for making splints. In the middle of the men's waiting room was the fixed steel chair for the reduction of dislocated shoulders. These operations were performed before the admiring gaze of the waiting patients. He also maintained a private hospital on a nearby street. He was medical officer to twenty-eight different labor organizations and societies of various types. It was not necessary

for him to wait for a practice to be built up, nor was a hospital connection an essential, since the injuries of Liverpool gave him ample clinical opportunity and experience.

His extraordinary mechanical genius enabled him to devise splints for individual cases and to cope with problems which seemed almost insoluble. In small insanitary houses he was able to treat cases of compound fracture and to obtain results which have not been improved upon even to the present day. Infection was overcome by the use of his medicated sawdust dressing; visits were paid to the patient three or four times a day, and the alignment and length of the limb checked. He insisted upon absolute obedience to his orders and woe betide the patient whose dressings or splints were disturbed during his absence.

He had a peculiar gift for the fashioning of splints, but also an infinite genius for taking pains. He accepted nothing short of perfection, and his Bed Knee Splint, for example, is the result of many modifications and simplifications of the original model.

Thomas's appearance was striking, and he was a Dickens character in real life. He was thin and pale, 5 ft., 4 in. in height. His features were sharp and clear cut, with a slightly receding forehead and dark grey eyes hidden behind thick lensed spectacles. He had a small, dark moustache and a thin pointed beard. He wore a black frock coat buttoned closely up to the neck with the famous smoke-room steward's cap tilted over his left eye. On his hands he wore heavy gauntlet gloves and, except when eating or sleeping, was never without a cigarette dangling from his lips. A silver cigarette case protruded from his coat pocket. The cap was worn to protect his injured eye, the coat and gloves to protect his chest and arms from the cold. He adopted the habit of smoking during an epidemic of cholera when he labored strenuously in the slums and continued it as a prophylactic measure.

His energy was amazing. He was said to have worked harder than any medical man of his day, for he never took a holiday, and in thirty years of practice was absent from home only six nights.

An average day's program will give some idea of his extraordinary capacity for work. He was off at six o'clock in the morning in his high phaeton, which was built on his own premises, to his own design by his own workmen. It was painted scarlet and was not inappropriately called the fire engine. A dozen patients had to be seen before breakfast, which consisted of a cup of tea and a couple of bananas — fruit which at that time was extremely scarce, but was obtained through friendly sea-captains. From nine until two he was

HUGH OWEN THOMAS

busy in his consulting rooms seeing thirty to forty patients, both medical and surgical cases. Old Colles fractures would be reduced on the spot with the Thomas wrench without an anesthetic, and dislocated shoulders of several weeks standing replaced in the surgical chair. After a simple mid-day meal, more patients were visited in their homes and at 4:30 operations such as crushing a stone, or amputation of a limb or breast were performed in his own private hospital. From six to seven he saw more patients in his surgery and at eight he made his final rounds of urgent cases in their homes. From nine-thirty to midnight he was to be found in his workshop or in his study.

On Sunday mornings he held his free clinic, to which patients numbering two or three hundred came from all over the country. They filled the house and overflowed into the neighboring streets. "When the bells were tolling for church the surgery at Nelson Street was filling with a congregation of suffering folk." Sunday evening was his only period of relaxation, and this time was devoted to music, his wife at the piano and he playing one of his silver flutes.

Numerous stories have been told of Thomas, most of them with no foundation in fact. His supposed roughness was a defense mechanism to save precious time. It is enough to say that he was a man of whom children were never afraid. He was always considerate in his dealings with other medical men, unless a patient came to him against his doctor's wish. If the case were one of mal-union or mal-position, he might speak his mind in no uncertain terms. Throughout his life he was the poor man's doctor, and his income was never over £3000 a year. During the height of the Orange and Catholic rioting he could go through the worst

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streets of Liverpool, in safety, cheered by both parties. ("God bless you, Doctor.")

Thomas became a licentiate of the Royal College of Surgeons in 1857, and was a member of the Liverpool Medical Institution, but very few academic honors came to him in his lifetime. Neither was he a philanthropist in the modern sense. He did not attempt to arouse public interest in special hospitals, nor did he grasp the relationship between slum conditions, and deformities.

Three fortunate circumstances helped to preserve Thomas's work for posterity. From his earliest days he was ignored by the medical profession partly from the belief that he was an unqualified bone-setter like his father, and also because he made no attempts to put his message across by publishing the principles which he had evolved, or by defending them at medical meetings. When he was invited to address a medical meeting he usually stayed at home with his practice. In 1875, a young surgeon of Liverpool, Mr. Rushton Parker, visited one of Thomas's patients who was suffering from a compound fracture of the tibia, which was fixed in a bed knee splint and supported by a crane so that the patient and splint could be easily moved without interfering with the fracture. Parker was at once impressed with the treatment, which he realized was revolutionary. Thomas was delighted, because for the first time a surgeon had come to see his work and was as enthusiastic as he himself. Parker introduced Thomas's splints and methods into some of the hospitals of Liverpool, but of more importance he induced Thomas to begin publishing the results of his work. As an outcome in 1875 appeared "Diseases of the Hip, Knee and Ankle Joints", the result of over 1000 cases treated during the previous twenty years. In the preface he states: "I am sure my method will reclaim this class of disease from the domains of excision and amputation." Thomas was unfortunate in the means he adopted for publishing his writings. They were issued in pamphlet form, full of polemical discussion in which he was prone to put the cart before the horse, and no attempt was made to sell them. For these reasons his writings are little known and hard to obtain.

The second fortunate circumstance which helped to rescue Thomas's work from oblivion was the visit of Dr. John Ridlon of Chicago in 1887. Ridlon was greatly impressed with the treatment he witnessed and the enormous number of cases under observation. He returned to America to spread the gospel and to keep alive in this country the teachings of Thomas. Ridlon personally made and applied the first Thomas bed knee splint used in the United States. The third, and most important circumstance was that his nephew, Sir Robert Jones, was able to enforce the use of Thomas splints in the allied armies during World War I and to teach the principles underlying their use to the medical officers of those various countries. No one but Jones could have transmitted Thomas to future generations of surgeons throughout the world.

During the Franco-Prussian war of 1870, Thomas offered his splints to the armies of both sides, but his invitation was declined. What a different story in World War I, when under the direction of Sir Robert Jones these splints became standard equipment for all the allied armies, and were even supplied to the Central Powers at their request.

The Principles of Hugh Owen Thomas

Sir John Hunter was accustomed to prescribe rest in treating muscular strains and injuries. Following him came John Hilton, who regarded rest as the most powerful aid which the surgeon could bring to the relief of disordered tissues. Thomas believed that an overdose of rest was impossible. To be effective it must be "enforced, uninterrupted, and prolonged".

His studies were all the result of observations on the living patient, in health and in disease, but never on conditions observed in the post-mortem room or laboratory.

The physiological creed on which Thomas based all his practice may be briefly stated:

1. All the tissues function in accordance with physiological laws, dependent upon harmony of the various tissues controlled mainly through the sympathetic nervous system.
2. An "inflamed" tissue or organ immediately ceases to function and will not respond to the artificial stimulus of drugs.
3. The body possesses a peculiar vitality by which it attempts to throw off disease. The physician can only assist natural physiological processes.
4. When a tissue or organ has suspended its normal physiological action, the rest of the body comes to the rescue by a physiological reflex, which we know as protective muscular reflex.

His contemporaries misread this symptom. They thought the joint was becoming stiff, and that it must be kept moving. Thomas, reading the physiological law more accurately, judged that rest for the joint was indicated. Therefore, he invented splints. If his splint effectively controlled the joint, muscle spasm rapidly disappeared and consequently the waste of nerve energy involved in muscle spasm was saved.

His appreciation and concept of the fundamental physiology of living tissues, placed him far in advance of his day concerning the action of drugs on healthy and diseased tissues.

One of Thomas's early publications was on "Intestinal Disease and Obstruction", and in this class of cases he applied his favorite principle of rest with his usual vigor. In his day the treatment consisted of enemata, violent purgatives, massage of the abdomen, and nerve stimulants. The mortality in intestinal obstruction at that time was enormous. Thomas had a different conception of the problem. He desired to reduce the intestinal tract to a mere lifeless tube, and so to regulate the diet that the intestinal contents above the obstruction would be transformed into a thin fluid, which would pass through the constriction. Consequently he prescribed a bland diet of sago, arrowroot with wine and lentil soups. Milk was prohibited. Fluids were given to allay thirst and morphia to put the bowel at rest. The foot of the bed was elevated ten inches to relieve fluid pressure and vomiting. Rarely he performed paracentesis if the abdomen became very tense. About the twenty-first day signs of recovery were seen, first a little flatus, and in another two days hard fecal matter, followed somewhat later by large bowel movements and enormous quantities of thin fecal fluid.

In cases of fracture of the neck of the femur, in order that the patient might escape the disturbance caused by the use of the bedpan, Thomas placed the bowel at rest by sedatives and a low diet, but he never succeeded in keeping it quiet beyond the twenty-first day.

His conception of rest differed from that of his predecessors. Hilton fixed a limb in a splint, and believed he had given it rest. Thomas distinguished this form of immobilization as "direct fixation". His ideal method of splinting he referred to as "indirect fixation". This is best illustrated by the bed knee splint which was so designed that it would prevent movement at the knee, and yet leave the joint uncompressed and the circulation of the limb unimpeded. Rest must be continued until all unsoundness had disappeared from the joint, and then the cure would be completed by the gradual return of natural voluntary movements. Therein lies the essential doctrine which Thomas so continually preached, and the application of these principles constitutes the difference between Thomas and his predecessors.

In designing his splints, Thomas showed his remarkable knowledge of anatomy and physiology. He observed that in walking or bending two joints were correlated in their action, the hip joint and the lumbo-sacral joints. He saw that limitation in the movement of the hip was compensated for by increased action in the lower part of the spine. On that observation he founded his test for early disease of the hip. This method is in use in every clinic today, and the surgeon can readily estimate the amount of flexion deformity, if present, or distinguish this condition from sciatica, lumbar disease or hysteria. In order to put the hip joint at rest, he saw that it could not be done by applying the long splint to the side of the body, like the old Buck's extension. The splint must cross the axis of the hip joint in order to completely control its movements, and it must be applied from behind and carried up the back to the dorsal segments of the ribs. Because no two people are shaped alike, the splint must be accurately moulded for each patient. It must be made of a pliable metal — wrought iron, and he invented the tools with which to shape it.

When he came to design his knee splint he used a basal or inguinal ring with inner and outer bars, simulating the ensheathing principle of the lobster's shell. He utilized the natural base of the limb — the ischial tuberosity and the iliac portion of the pelvis — as a support. By uniting the lateral supports below the foot he furnished the lower limb with a new and temporary skeleton which relieved the bones of all stress and gave the muscular engines complete rest. A pattern attached to the shoe of the sound limb equalized the length of the legs. When the time came for weight bearing, he simply cut off the lateral bars, turned them into a tunnel under the sole of the shoe, and the splint became a caliper walking splint.

In the upper limb he recognized that two joints were involved — the scapulo-thoracic and the scapulo-humeral. Before any manipulation of the shoulder could be performed, the scapula must be fixed. He again made use of the basal ring which was built into the side of his dislocation chair. Furthermore, he grasped, as no one had ever done before, the essential differences in function between the upper and lower limbs. The lower limbs are for support and locomotion and in order to rest their muscles the limb must be fixed in long rigid splints. But the upper limbs are made for free movement; they have no rigid basal girdle to which a fixation apparatus may be applied. So he designed his "gauge-halter", which is simply a handkerchief tied around the neck so that its loose ends fall down on the breast.

In the treatment of deformities of the foot, he reveals a sound knowledge of function. For the early stages of flat foot, he fashioned the crooked heels, which we know by his name, to let the "leather do the labor" as he put it, and relieve the tired leg muscles. He learned this method from watching flat foot develop in patients who had sustained Pott's fractures.

Of great importance from a practical point of view is his doctrine of "unsoundness". An unsound part is one which is the site of disease or injury, one in which inflammatory processes are taking place. Such a part is plastic and can be moulded. The deformed knee can be most easily straightened when it is in an inflammatory state, and a badly set fracture when it is in a state of healing.

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POST-CONVALESCENT CARE OF RHEUMATIC FEVER*

LOUIS A. SIERACKI, M.D.

The Author. *Louis A. Sieracki, M.D., of Boston. Assistant Physician, Children's Hospital, Boston; Medical Director, Sharon Sanatorium.*

INCREASING interest in the problem of rheumatic fever has developed in the past few years. Since it is a disease that carries not only a high mortality rate, but also a high morbidity rate particularly in children and young adults, it has gained increasing importance as a public health problem.[1] The development of state programs for children with heart disease and conditions leading to heart disease in co-operation with the Children's Bureau of the United States Department of Labor[2] has helped to arouse public interest in the disease and has stimulated the medical profession to greater endeavor in understanding the disease. Numerous cases of acute rheumatic fever have occurred in the personnel of the United States Armed Forces in World War II, and various workers in the field of rheumatic fever, both military and civilian, have undertaken to try to solve the problem. In this presentation, we are not going to concern ourselves with the diagnosis of the disease. We will assume that we know all the signs and symptoms of rheumatic fever and all the signs that lead to a diagnosis of heart disease. The diagnostic criteria of rheumatic fever have been well presented recently by Jones.[3]

Once the diagnosis is established, the treatment of rheumatic fever in the acute and subacute stages shows a fairly definite pattern whether it is in a rheumatic fever hospital or sanatorium, convalescent home, foster home, or patient's own home. All authorities agree that bed rest is essential until all signs and symptoms of active infection have subsided. During the subacute stage, various educational, social, and recreational programs are carried out. These are continued throughout the first few weeks of the inactive or convalescent stage when the patient is on exercise. It is usually at this time that his period of observation becomes less frequent, and it is at this point that our present discussion begins.

Our patient with quiescent rheumatic fever may or may not have escaped heart disease. If he has developed heart disease, it may have taken him a little longer to reach his present status of being up out of bed from six to eight hours daily. During this exercise period, he has schooling in a classroom if he is in a sanatorium, or a home-teacher if he is in his own home or in a foster home. In addition to this, his time has been spent in doing some occupational therapy or in recreation. He has been allowed to go to the bathroom at will, to sit at table for meals, and to go for short walks. In the middle of the day, he has a long rest.

If the patient has been away from home, he is discharged to the care of his parents and advised to return to a clinic at a certain specified time. Unless specific instructions are given at the time of discharge home, misunderstandings may arise, and the patient given a full day's privilege of overwork which may lead to trouble. At the Sharon Sanatorium, we have found it expedient to give a printed list of a patient's activities and rest periods which should be followed until the patient is seen again at the parent-clinic. In addition to exercise and rest instructions, a list of the things that are essential in the diet is incorporated in the printed form.

Having left an institution for the care of rheumatic fever or having been discharged by his local doctor from further home visits, our patient should not be allowed to partake in a full day's activity with the other neighborhood children. His schedule for a time should remain the same as if he were under constant medical supervision. The parents in this case are the supervisors but, unfortunately, many times they have had no instruction as to the limits of the child's activity. He is now theoretically well. Can he run, play baseball, swim, skate? What can he do? The answers to these will depend to some extent on the severity of his past infection and on the amount of cardiac involvement.

Before all these questions can be answered, the child's home must be prepared for his coming. If it can be arranged, he should be allowed the privilege of a single room; if this is impossible, perhaps a single bed. In this way he is somewhat guarded from contact with members of his family who might have upper respiratory infections. If a rheumatic subject develops an upper respiratory tract infection, he is instructed to go to bed for a

*Presented at the Quarterly Meeting of the Children's Heart Association of Rhode Island, at Agawam Hunt Club, East Providence, June 27, 1945.

few days even though the infection is mild. If he has a fair amount of heart disease, arrangements should be made so that his family does not live in a third- or fourth-floor apartment. Unfortunately, so many of these patients come from the low-income group that at times, it is necessary to secure the aid of some agency to supply food, or the money for it, in order to help with nutrition. As much as possible should be done in the home to make it a better place, especially if it is one of those ill-kept, backhall, third- or fourth-floor tenements.

If our patient is discharged home during the season for hemolytic streptococcal infections, he is kept from school and a home-teacher is provided. Parents are asked not to take him to crowded places, and since he cannot attend school, movies are denied him. Numerous authors have shown the relationship of hemolytic streptococcal infections to rheumatic fever, and these patients should be protected as much as possible from coming in contact with these infections.

Having prepared the home, we are again on our way. We assume that it is now three months since our patient has been allowed out of bed. Our rule is, for the first year after his acute illness, to prevent an individual who has recovered from a recent bout of rheumatic fever from partaking in most forms of strenuous exercise, especially that which involves competition. This is the instruction given to both cardiacs and to non-cardiacs since the latter may show evidence of heart disease at a future date. The patient is allowed to increase his time out of bed to eight or ten hours daily. During his time up, he is allowed to walk up and down stairs, to walk to and from the store if it is not over half a mile, to go to school if school privileges are allowed, to go to the beach but to keep out of water above the knees, to throw or bat a baseball, and even to run a short distance after one, but not to play a real game, and to go for auto rides. During this first year, he is forbidden to swim, ride a bicycle, and jump rope. He is instructed to take a daily rest-period of one to two hours at mid-day. In other words, without making him conscious of it, he is still a semi-invalid. Most of our cardiac patients will be able to tolerate this form of exercise; those who cannot are allowed as much activity as is possible within the limit of dyspnea.

Usually after discharge from constant medical supervision, the patient is seen in the clinic or office fairly frequently so that he may be evaluated for further recurrence of infection. At first, the period of observation may be monthly, then every six to eight weeks. After the first year, visits are made every three to six months, depending on the amount of heart disease and the presence or absence of intercurrent infection.

A full year after the active stage of rheumatic fever, the non-cardiac is given full freedom in the amount of exercise. Only one minor restriction is put on him—he is asked to take a rest at noon. He does not usually heed this advice, which is given because it is felt that this noon rest helps to increase his physical reserve in combating possible infection. The patient with murmurs, with slight or no cardiac enlargement, is also given the same freedom since his physical effort will have no effect on the amount of heart damage once the infection has become definitely quiescent. These patients do not necessarily need special vocational training although it might be advisable as a prophylactic measure since recurrences do occur and might lead to invalidism.

It is unfortunate that the activities of many children who have minimal heart damage are restricted. Some of these restrictions are based on the fact that a murmur is present which does not necessarily preclude the diagnosis of heart disease. These cases are usually picked up in a school examination and unless a full evaluation is made, certain restrictions are placed which lead to "heart consciousness" and neuro-circulatory asthenia.

The more severe cardiac, the one with a moderate or severe enlargement is limited in his activities at all times. He should have no gym work and no competitive athletics. He should not be made to climb too many stairs. He will often limit his own activity because of the presence of dyspnea. If any child's exercise tolerance becomes less during a period of observation than it was formerly, effort should be made to establish the probability of recurrent active rheumatic infection.

The functional capacity and therapeutic classification of the New York Heart Association[4] helps to classify a case in the mind of an expert in heart disease, but does not help most people to know just what to do with a given case. The recent recommendations by Hiss[5] as used by the schools of Syracuse, New York, merit recognition. The amount of exercise that each individual can do is easily determined from Hiss' table. His recommendations start with those cases who can do most and go down to those who need bed care. They are as follows: 1. No restrictions, 2. all gymnastics but no competitive athletics, 3. mild gymnastics, 4. no physical exertion, 5. rest periods in school and restrictions of recess activities, 6. school for the handicapped, 7. child to be furnished transportation to and from school by parents, 8. home teacher, and 9. convalescent home. These recommendations are used after a careful diagnosis and evaluation of activity has been made. The child is kept in the school for the handicapped only as long as is necessary and is returned to his home school as soon as possible.

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PNEUMOCOCCIC MENINGITIS SUCCESSFULLY TREATED WITH COMBINED PENICILLIN AND SULFADIAZINE THERAPY*

MAJOR ROBERT G. MURPHY, MC, A.U.S.
and
LT. COLONEL FRANK B. CUTTS, MC, A.U.S.

The Authors. *Major Robert G. Murphy, MC, and Lt. Colonel Frank B. Cutts, both of Providence, members of the 48th Evacuation Hospital which was stationed in the China-Burma-India theater of war operations for more than two years.*

A RECENT report by Waring and Smith[1] has recorded the successful treatment of several cases of pneumococcic meningitis by combined penicillin and sulfonamide therapy. They present evidence indicating that this combination is more effective than either agent alone. Our report is presented to record an additional case so treated.

Report of Case

A white soldier, age 33, was admitted to this hospital in Burma on 19 March 1945, complaining of a chill followed by nausea, vomiting, fever, dizziness, backache, substernal pain and cough with whitish sputum, all these symptoms commencing twelve hours before admission. Subsequent to recovery the patient recalled having had a right ear ache, followed by a purulent discharge from this ear which lasted two days, occurring two weeks before admission. The only past history of significance was an apparent toxic reaction to sulfadiazine in 1941. This reaction was described as "jaundice, saturation of the blood with the drug and abnormal changes in the white blood cells". This followed 6.0 grams of sulfadiazine daily for one week.

Physical examination on admission was negative except for a temperature of 103 degrees and a pulse rate of 140. The lungs were entirely negative to examination and the neck was not stiff. On the third hospital day fine moist rales were heard over the left anterior chest and in the left axilla. A chest X-ray confirmed the diagnosis of pneumonia fanning out from the left hilar region. Because of his history of sensitivity to sulfadiazine, penicillin, 40,000 units intramuscularly every four hours, was commenced. In the evening, several hours later, the patient became irrational. There was slight stiffness of his neck and a weakly positive bilateral Kernig's sign. Lumbar puncture was done. The spinal fluid was under increased pressure and cloudy with a cell count of 600 cells per cu. mm. The differential count on this fluid 76% polymorphonuclear cells and 24% lymphocytes. The total protein was 203 mg.% and gram positive extracellular diplococci were demonstrated. Diplococcus pneumoniae, Type I, was cultured from this specimen.

The following morning it was decided to give sodium sulfadiazine intravenously until oral administration was possible, and, in addition to the penicillin intramuscularly, 10,000 units of penicillin intrathecally in 10 cc. of normal saline each day. During most of the period of administration intramuscular penicillin was given every three hours, although on a few occasions the interval between doses was four hours. The spinal fluid cell count rose to 3750 on the second day of intrathecal treatment and was normal on the fifth day. One day after the first intraspinal administration of penicillin organisms could no longer be demonstrated in the spinal fluid on smear. For the first 48 hours the patient remained unconscious. 24 hours later he was conscious, rational, and answered questions intelligently. At this time examination of the lungs and nervous system was negative. Convalescence was uneventful except for a cellulitis of the right buttock following intramuscular paraldehyde which caused a low grade fever for several days. As soon as the patient could take oral medication, 12 to 16 grams of sodium bicarbonate was given in divided doses daily to prevent renal complications. As determined by daily blood counts and urine examinations, there were no toxic effects noted from the sulfadiazine in spite of his previous history. The relationship between the clinical signs, symptoms and laboratory data during the 11 days of specific therapy is shown in the accompanying table.

At the present time 33 days after concluding specific therapy, the patient is entirely well.

*Approved for publication by the Bureau of Public Relations, War Department, Washington, D. C.

[1]Waring, A. J. Jr., and Smith, M. H. D. Combined Penicillin and Sulfonemide Therapy in the Treatment of Pneumococcic Meningitis. J. A. M. A. 126:418 (Oct. 14) 1944.

TABLE I

DATE (MARCH 1945)	21st	22nd	23rd	24th	25th	26th	27th*	28th	29th	30th	31st
SENSORIUM	Coma	Coma	Semi-Coma	Normal	.....	.....	.....	.....	.....	.....	.....
STIFFNESS OF NECK	+	+	+	0	0	0	0	0	0	0	0
MAXIMUM TEMP.	104.2	105.8	103.6	102.8	101	99.8	100	101.4	101.8	101.4	99.8
SPINAL FLUID											
CELL COUNT	600	1450	3750	3050	108	3	0	3	.....	.....	.....
PNEUMOCOCCI PRESENT	+	+	0	0	0	0	0	0	.....	.....	.....
THERAPY											
PENICILLIN I. M. (thousand units)	120	205	200	200	200	200	200	90	70	70	40
PENICILLIN I. T. (thousand units)	0	10	10	10	10	10	10	10	.....	.....	.....
SOD. SULFADIAZINE I. V. (Grams)	0	8	6	3	.....	.....	.....	.....	.....	.....	.....
SULFADIAZINE ORALLY (Grams)	0	0	0	3	4	4	4	4	4	4	4

**Cellulitis of right buttock following injection of paraldehyde first noted.*

HUGH OWEN THOMAS

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Thomas had many methods of setting up unsoundness in a part — by percussing, by wrenching or by damming the circulation. Twenty-seven years after Thomas first used damming, Bier published this method of treatment and British and American surgeons spoke of it as Bier's method.

He employed percussion by a rubber protected hammer at the site of an ununited fracture with damming by placing a rubber band above and one below the lesion. In a young girl with slipping patellae, he percussed the outer condyles in order to enlarge them so that the patellae could not ride over the condyles. This treatment was carried out once a week on the left knee for five months and on the right knee for nine months. This anecdote illustrates both his remarkable gift for taking pains and his personal care in the service of his patients.

Eighty years ago the common practice of surgeons was to perform excision of diseased joints. As a medical student he heard Syme extol its benefits, and Spence proclaimed it would open up a new world in surgery. In Thomas's opinion this meant a world of unnecessarily maimed limbs — limbs which could be saved if the surgeon were willing to play the humble role of Nature's assistant.

In 1883 he published "The Principles of the Treatment of Diseased Joints". Much of this book was a recapitulation of his first work on the hip, knee and ankle joints, but he took the opportunity to emphasize his principles supported by a mass of evidence. He laid down the truism that "No amount of rest without disease will produce ankylosis, although prolonged rest may stiffen a joint: this is a trivial and only a temporary hindrance." He declared that ankylosis should be classified not as fibrous or bony according to its pathology, but rather as sound or unsound. A sound ankylosis would not change its angle when subjected to normal use, while an unsound ankylosis would cause the joint to become deformed.

One year later (1884) he took up the thorny subject of "Fractures of the Neck of the Femur". Thomas distinguished between the typical fracture of the neck with shortening, and eversion of the leg, and a condition which he called an inflamed hip joint. He apparently failed to realize that these latter cases were in reality impacted fractures of the neck of the femur. He emphasized the importance of securing full length of the limb and internal rotation of the leg. Minute details were given as to how this position was to be maintained, and this procedure of bringing the fractured surfaces into apposition cannot be improved upon even today.

In "The Principles of the Treatment of Fractures and Dislocations" he enunciated the principles underlying the treatment of drop wrist. They are summed up as follows:

(1) Weakening of one group of muscles is usually followed by contraction of its opponents.

(2) The contraction rapidly becomes a contracture.

(3) No weakened muscle can recover its strength while it is abnormally elongated.

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(4) One essential for the recovery of a weakened muscle is the position of relaxation of that muscle.

Here are defined the essential doctrines which must guide the surgeon in treating muscular weakness and paralysis.

During the last few years of his life he published a volume on injuries of the upper extremity; a companion work on the lower extremity and a controversial book entitled an "Argument with the Censor of St. Luke's Hospital". The last was a scathing denunciation of the complete lack of principles which guided the American School of Orthopaedic Surgery and an equally spirited defense of his friend John Ridlon, who had suffered through his championship of Thomas.

In the early eighteen-seventies, he was full of activity. He made ingenious fracture splints on wheels, and cranes were attatched to the walls so that limbs could be supported freely without jar or jolt. He invented his two-way aspirator, his automatic hypodermic syringe which required only an occasional recharge. His inventive genius included even gadgets for lightening household labors and he improved on his box stalls and on the stops of his silver flutes.

Some of Thomas's keen observations have never even found their way into modern textbooks. For instance he gives a very clear indication as to when disease appears, when recovery is occurring, and when it has actually taken place. Although an apostle of rest, he never kept his joint cases long in bed. He divided the mechanical treatment into four stages: (1) The patient was kept in bed until the night pains had ceased, unless suppuration was suspected. (2) The patient was allowed up on crutches with a patten under the shoe of the sound limb. (3) The splint was removed at night but continued with crutches and patten during the day. (4) The splint was omitted and crutches and patten continued.

It is interesting to note that while he employed both anesthesia and antisepsis in his earlier years, later in life he gave up both of these aids to a large extent. He practiced open surgery, as he called it, by which I assume he means aseptic surgery. Thomas was scrupulous in his preparation of the field of operation, in the care of his own hands, and his instruments were dipped in a solution of carbolic acid in oil.

In 1891, while making a journey to visit a patient at some distance from Liverpool, he was exposed to bitter cold, and died from pneumonia a few days later.

In speaking of Thomas's work, it is sufficient to point out that there has been a revival of the methods he adopted to combat disease many long years after his death. His passion for accurate knowledge and his recognition of physiological principles of tissue life and repair made him seek fundamental rules of treatment. His appreciation of the value of physiological rest drove his logical mind to reduce the management of disease to a definite system, and to design splints to achieve his purpose with efficiency.

Sir Arthur Keith says of him: "Yet were I to emphasize the greatest legacy he has left to medicine, it would not be his splints or appliances, his principles, his practical applications of anatomy and physiology, but his personal care in the service of his patients. No trouble was too great for him if his attention was needed to effect a cure."

Such was the man the centenary of whose birth in 1834 was remembered by orthopaedic surgeons the world over; Hugh Owen Thomas, M. R. C. S., a club doctor, beloved by his own people, to whose service he devoted his strength and his life.

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MEDICAL OPINION IN RHODE ISLAND

Report 1. DIAGNOSTIC CENTERS

Prepared by the

COMMITTEE ON POSTGRADUATE EDUCATION

Alex M. Burgess, M.D., B. Earl Clarke, M.D., Harmon P. B. Jordan, M.D., Elihu S. Wing, M.D., and John F. Kenney, M.D.

(The following report is the first of a series to be prepared by the Committee on Postgraduate Education based on statistics gathered as the result of the questionnaire sent to each member of the Society in April, 1945. The Editor.)

IN A questionnaire sent to all members of the Rhode Island Medical Society in April of this year and designed to furnish information regarding the conditions of medical practice in the state, several questions were asked as to the establishment of diagnostic centers, group practice and an industrial clinic. The purpose was to determine the "popularity of these forms of service and the need for them." The present summary deals with the opinion of the profession, as expressed in the answers received, as to the establishment of diagnostic centers in Rhode Island. The three questions on this subject are as follows:

No. 19 — Approximately how many of your patients in the past year: (a) Voluntarily requested or sought study or treatment at an out-of-state clinic or hospital? (b) How many went to such clinics or hospitals at your suggestion?

No. 20. How do you look upon the establishment of one or more diagnostic centers for hospitalized patients in Rhode Island?

No. 21. If you favor such centers how do you think they could be most effectively established and operated?

In the replies received there were 177 physicians who answered one or more of these questions. This may be considered a good cross section of the profession and represents about 30 per cent of possible replies. (There are approximately 600 active physicians now in the state.) The answers were carefully studied and in the results here reported where an opinion appeared doubtful or not definite it was classed as "No Opinion".

Question No. 19. (The estimated number of patients who voluntarily sought admission to out of state clinics or were referred to such clinics). In answering this question a number of physicians expressed their estimates in percentages which are difficult of interpretation and on this account are omitted. The only answers tabulated are those in which the physician estimated the actual number of patients who during the year had gone to out of state clinics with or without his advice. The results are as follows:

Number of physicians who answered by giving definite figures — 92.

Physicians who reported no patients, to their knowledge, attending out of state clinics — 17.

The 75 physicians who reported patients visiting out of state clinics estimated that a total of 826 patients went to such clinics without being referred and 561 were referred by them. This represents an average of six referred patients and nine not referred per doctor (of the 92 who reported). These figures of course are merely estimates but they probably are conservative. They certainly indicate a great exodus of patients to out of state clinics more often than not without their doctor's knowledge or consent. That such a condition exists is well known to the average Rhode Island doctor. It must represent a feeling on the part of physicians, and even more on the part of the public, that the best facilities, diagnostic and therapeutic, are not available in our state. It therefore indicates a need, and while there will doubtless always be an occasional patient who believes that he gains by going away, especially to a larger center such as Boston, it would be reasonable to assume that the establishment of one or more first class diagnostic centers would in the main satisfy this need.

Question No. 20. (How do you look upon the establishment of one or more diagnostic centers for hospitalized patients in Rhode Island?) This question was answered by 177 doctors as follows:

In favor of establishing such centers — 102

Against establishing such centers — 24

With no opinion or doubtful — 33.

Medical opinion, then, based on the definite replies of 144 physicians, is 6 to 1 in favor of the establishment of diagnostic clinics in the state. If the group be divided into specialists, general practitioners and those who work partly in a specialty and partly in general practice the results are of interest as it appears that what opposition there is to such clinics is almost entirely confined to men

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who state that they are specialists. The figures are as follows:—

(1) Specialists — 93
In favor — 51 Against — 20
No opinion — 22

(2) Specialists who also do general practice—36
In favor — 29 Against — 2
No opinion — 5

(3) General Practitioners — 47
In favor — 40 Against — 3
No opinion — 4

The comments of those who oppose the establishment of diagnostic clinics are of interest. Eight physicians expressed the opinion that such clinics were "not needed" while six stated that they believed that present hospital facilities are sufficient. "Every good hospital should be a diagnostic center", "We are too close to Boston to be successful" and "Not unless we had a medical school" are quotations from three of the replies.

It is quite evident, however, that there is an overwhelming sentiment in favor of establishing one or more diagnostic centers. Many of those who replied in favor of the idea were quite emphatic, stating that it was "a great need" or "a crying need" or the like.

Question No. 21. (If you favor such centers, how do you think they could be most effectively established and operated?).

A large number of the 120 doctors whose replies were favorable had no definite suggestions as to how diagnostic centers should be established. There were a number, however, who did express opinions or whose comments are of interest.

31 physicians stated that the centers should be established and operated by hospitals. Of these, 8 specified that the Rhode Island Hospital should undertake the project. 9 physicians expressed the belief that the Rhode Island Medical Society should establish the centers and 4 that they should be privately established. One physician felt that they should be controlled by the state and two that a joint control by a hospital and the medical society was to be preferred.

Certain other comments and opinions are of interest. Eight replies emphasized the idea that the centers should be diagnostic and should protect the interest of the referring physician by returning the patient to him and not advising treatment except as requested by him. Three doctors suggested a central diagnostic clinic in Providence with branch clinics in smaller communities. Five favored a "full time" paid staff for the centers. Two emphasized the desirability of the center's giving service at a "reasonable price". Six physicians specified the J. H. Pratt Diagnostic Hospital as an excellent model and several other clinics including the Mt. Sinai, Lahey, Mayo, and Massachusetts General were mentioned.

Comment

From the replies to the three questions the following deductions can be made. There is, in the opinion of a representative group of Rhode Island physicians, a need for one or more diagnostic centers. This need is evidenced by the large number of patients who go to out-of-state clinics, with or without their physician's approval. The doctors of Rhode Island are strongly in favor of establishing such a center, or centers each of which should be organized by or in connection with a hospital. The need is admitted by physicians generally but apparently is felt most keenly by those in general practice. This expression of medical opinion is important and definite and may well be considered by any hospital in a postition to establish and operate a first class diagnostic center as a mandate from the local profession to do so.

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FIFTY YEARS OF X-RAYS

WITHIN a few weeks will occur the 50th anniversary of the discovery of x-rays by William Conrad Roentgen. This reminder that x-rays have been known for only half a century will probably startle many of the physicians who have graduated from medical schools during the last two or three decades. To them the x-rays are such an indispensable part of their daily medical armamentarium that the concept of a medical practice without their help is almost unthinkable.

Yet it was only on November 8th, 1895, that Roentgen discovered the existence of an invisible and hitherto unknown "ray" which had the capacity, among other qualities, of penetrating solid substances. Within six weeks Roentgen learned enough about these strange rays to write a fairly comprehensive paper and present it before one of the small societies at the University of Wurzburg, Germany, where he was professor of physics. Before the end of the following spring a series of three papers in all had been published, covering very completely and comprehensively all the physical data he had been able to gather about these mysterious new rays. In fact these three papers were so complete that it was not until 1910 that the researches of Bragg and his asociates with crystals added anything of importance to this fundamental knowledge of the nature and qualities of these rays.

This discovery instituted a real revolution not only in medical ideas but also in the physicists' concepts of the constitution of matter. From this time a new vocabulary began, with words such as *rays, radiation, radio-activity,* etc. Shortly afterwards Bequerel discovered analogous rays coming out of uranium compounds. This led directly to the discovery of radium in 1898 by the Curies. The later production of artificial radio-activity by Irene Jolie-Curie was a logical sequence. Then came the chain of methods of bombarding the atom, followed by complete fission of the atom, and finally the production of the atomic bomb, with its tremendous future possibilities for good or for evil.

The history of the medical application of x-rays is really a narrative of the improvements in practically every branch of medicine during these fifty years. A mere mention of all of them is not possible in this brief review. We can only call attention to a few of the more important.

At first the use of the rays was restricted to the recognition of fractures and the location of foreign bodies. Very soon the examination was extended to the study of all types of bone disease. Modern orthopedic surgery could have reached its present high plane only through the continual development and expansion in x-ray diagnosis.

The development of Urology as a special branch of surgery dates back to the introduction of the

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cystoscope. Even more important however have been the strides that took place in this specialty with the development of x-ray methods of examination, particularly the use of urography with contrast media. At first only the retrograde examination was used, but this was later supplemented by the intravenous method.

In internal medicine the study of chest diseases was finally made reasonably accurate by the improvements in x-ray diagnosis. The use of survey or "screening" studies of large groups of the population, made possible only by improvements in x-ray apparatus and films, has been a most important factor in the fight for control of pulmonary tuberculosis.

With the introduction of the barium meal and the barium enema the field of gastro-enterology has been radically transformed. The possibility of making pre-operative diagnoses has altered the entire status of abdominal surgery. Similarly the rapid advances in thoracic surgery have been dependent to a great degree upon increasing accuracy in methods of x-ray examination.

The diagnostic use of air and opaque contrast substances in the cavities of the brain and in the spinal canal has likewise been of great help in neuro-surgery and in neurology generally.

Not only in diagnosis but also in therapy the x-rays have proved their usefulness. Immediately after the discovery in 1895 they were applied with benefit in the treatment of cancer of various types. Within a short period of time other diseases such as leukemia were found to be susceptible of help by radiation.

As the types of machines and x-ray tubes were improved, the methods of x-ray treatment were also advanced. Higher voltages and better filtration were employed, and later combination with radium treatment. In recent years extremely high voltages from one million to four million have been utilized. These have made it possible in certain instances to arrest types of cancer that could not be modified by the lower voltage x-rays.

During the past two decades the rays have been found more and more useful in the treatment of various benign inflammatory processes, especially superficial pyogenic infections.

As recently as 20 years ago many of the more complicated x-ray diagnostic methods which are now used daily were then entirely unknown. In view of these tremendously rapid changes, the specialty of Roentgenology is being transformed more quickly than any other branch of medicine. In another 20 or 25 years equally unpredictable and important new methods will undoubtedly be commonplace.

READING FOR NON-MEDICAL GROWN-UPS

Medical men feel that there is a large amount of science now associated with the art of medicine, and in common with other scientists they are distressed by the "popular" writing about their work. Not only is there a lack of knowledge shown, but the contributions by men presumably well-informed often betray a prostitution and pandering to the people's fondness for Hollywood types of stories.

Some earnest but overenthusiastic workers have a small series of cases where their new methods seem to show wonderful results. They hopefully report this in some medical journal and immediately the small lay journal with the immense circulation has a livid article telling that this great problem of mankind is solved. Of course, all our patients and their friends read this, and we are besought or commanded to mend our hidebound and old-fashioned ways. This is really a serious problem. A surgical friend of ours was set to amputate a leg for gangrene of the foot when a well-meaning clergyman, who had read of the wonders performed by the alternate pressure boot, intervened. There was a considerable interlude before the amateur student of the healing art was convinced that the foot was dead and had to be removed. As a bishop of London said, "No people cause so much harm as those who go about doing good."

Well hidden, we fear, from most doctors, in the September ATLANTIC, is an article by Dr. John F. Fulton of Yale on "Penicillin, Plasma Fractionation, and the Physician." This is factual and dispassionate but, we believe, will be interesting to all truly anxious for a proper view of medical progress. And it should be well worth while for physicians to read it. Dr. Fulton leads up to his subject through a discussion of the results achieved by the medical services in this war, which results have been proudly proclaimed by the Surgeons General. We take the liberty to quote from the article:

"First in order of importance, then, in explaining the reduction in mortality rates, is the fact that our wounded at the battle fronts are coming under the care of better trained and educated medical officers than in the last war . . . . .

"We should reflect long and seriously on this point because our military forces, the army in particular, have unwittingly done everything conceivable — and continue in this ill-timed policy — to lower the standards of medical education in this country and to hinder adequate training of pre-medical students . . . . .

"Because of the continued refusal of the Congress, Selective Service, and the Secretary of War to defer students preparing for the professions, there are virtually no physically fit male applicants

from whom to select. On this point the British learned their lesson in the last war, ... and in this war in consequence made it mandatory that a proportion of their younger talent should be deferred for the professions. Our colleagues in the Soviet Union have done the same; in fact, they have gone even further than the British in deferring students entering the sciences. But we have deliberately and recklessly refused to defer or otherwise to protect — save in very rare instances — our younger scientific talent."

Turning from this, as he says, to a far brighter side, he shows how penicillin was not the result of a miracle but, as scientists know is always the case, followed much hard work. "The development of penicillin and its recognition as the most important therapeutic agent ever to be introduced into the healing art lacks, as did the introduction of surgical anesthesia, the element of a clear-cut and isolated discovery for which full credit should be given to one man. 'Discoveries' are not made this way!" Having given a short sketch of the development of this work he continues:

"It is worthy of emphasis in this connection that all the preliminary work that led to establishment of the therapeutic effectiveness of penicillin was carried out on animals. Without animal experimentation we should never have had penicillin for use in man. It is impossible as yet to estimate how many lives have actually been saved so far by penicillin, since not all the factors can be readily appraised, but I should think it no exaggeration to say that the handful of mice, rats, and cats which Howard Florey and his colleagues used during 1939 and 1940 has already saved many thousands of human lives in the war theaters alone.

"The history of penicillin falls largely into three phases: (1) Fleming's initial observation, which, although important, ended in failure as far as practical therapeutic application was concerned; (2) the successful extraction and purification of penicillin by Florey and his collaborators and the demonstration of its therapeutic properties; (3) the remarkable feat of commercial production, for which our resourceful and energetic drug houses, working under the direction of Dr. A. Newton Richards, ... are largely responsible."

Finally, he sketches the important work of organization for producing and using penicillin in this country, the dramatic story of the Yale professor's wife who was the first patient here to receive it and tells briefly of the pathogenic organisms which are affected by it.

The story of penicillin is well known to the general public although undoubtedly not so accurately as they can get it from this article. Probably Blood Fractionation is not so familiar to them. Dr. Fulton tells of the organization of the group headed by Dr. Cohn and of their isolation and study of many active factors found in human blood. Many of us were fortunate to be at the meeting of the Providence Medical Association last spring when Dr. Orville T. Bailey sketched for us this dramatic story.

Dr. Cohn, who years ago extracted and purified the liver principle for George Minot's therapy in pernicious anemia, had clinicians, chemists, pathologists and inmumologists working with him. Starting with the large-scale production of serum and plasma to substitute for the bulky whole blood, they proceeded to extract many other proteins. We mention a few of their achievements. After the albumin was freed of the globulins whose agglutinins cause reactions, among the latter were found those giving inmunity in measles and infectious jaundice and another that was responsible for the specific blood types. Surgeons will be particularly interested in the development of fibrinogen and thrombin and fibrin foam to control bleeding and fibrin film to eliminate adhesions.

After this recital of thrilling and actual events in the scientific medical world, Dr. Fulton draws this moral:

"We shall show our wisdom in the ways and means chosen for the support of our post-war medical research. We must decide whether it is to be placed in the hands of bureaucratic Federal agencies that will be subject to political influence, or whether it will be set up under the supervision of recognized scientific bodies which are independent of political control."

We trust that our readers who may have missed the ATLANTIC for September will promptly order a copy and then see that some of their non-medical friends read it.

WATER POLLUTION

The medical profession of Rhode Island has long advocated that some definite action be taken to eliminate the pollution of the waters of this State. As recently as last May the Providence Medical Association, already launched in a smoke pollution program, adopted a resolution urging the enforcement of existing laws and the drafting of necessary new ones to control water pollution.

Last June the National Advisory Health Council, meeting in Washington, approved a statement of policy of the Public Health Service relative to federal legislation on water pollution control which noted that "it is generally recognized that there is need for Federal legislation to provide a stimulus to water pollution abatement activities and the necessary coordination of existing control authorities". The statement also cited the interest of the Public Health Service in any federal legislation dealing with pollution control that, among other

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things, provides "the authorizations for appropriation of funds for allocation to States for promotion, investigations, and preparation of engineering reports and *programs* necessary for the prevention and abatement of water pollution."

Undoubtedly federal legislation is needed in the question of interstate water pollution problems where the scope of activity for years has been merely that of investigation. But the problem for Rhode Island is one that is limited to our own confines. The action recently initiated whereby local funds are being sought to finance the present study which we infer would advance worthwhile recommendations, is most commendable and deserving of public support. Pending the outcome of this new study the existing laws should be enforced, and if necessary amendments made to them when the Assembly meets in January.

RHEUMATIC FEVER

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No discussion of this sort would be complete without some mention of the use of the sulfonamides in quiescent cases of rheumatic fever. The value of sulfonamide prophylaxis in the prevention of recurrences of rheumatic fever has been recently reviewed by Thomas.[6] In most of the studies presented, sulfanilamide was the drug used. Except for the use of sulfadiazine in mass prophylaxis in the Armed Forces, no report has appeared regarding the use of the less toxic of the sulfonamides in civilian practice. The amount of work involved and the lack of personnel in the past few years has prevented the use of these drugs on a wider scale. Although the use of these drugs has tremendous value, many questions are yet to be answered and their use is, at present, not the final answer to the problem of prevention of rheumatic fever. Up to the present, I have found no definite value in the use of the salicylates in the prevention of recurrences as advocated by Coburn and Moore.[7]

Summary

The care of rheumatic fever in the quiescent stage involves the need of a good home, instructions in the amount of rest and the amount and type of exercise that can be done, frequent follow-up, and the use of all possible measures in the prevention of recurrences.

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HOSPITAL ASSOCIATION OF RHODE ISLAND

Nurses training schools in Hospitals throughout the state have now started their 1948 classes. Homeopathic Hospital has enrolled a total of 36 students, of whom 32 are cadets. Thirty of the thirty-two report that they would have enrolled at their own expense if the cadet arrangement had not been available. The Memorial Hospital has an enrollment of 31, all cadets. This is the largest class in the Hospital's history. St. Joseph's Hospital reports an enrollment of 40, of which 37 are cadets.

* * * * *

Mr. Carl A. Lindblad, President of the New England Hospital Assembly, informs us that the 1946 Conference will be held in March and that a meeting for discussing plans will be held in October. All Trustees and Officers of the Assembly are expected to attend this meeting.

* * * * *

Mr. Donald B. Lindsley, who left Bradley Hospital in February 1943 to conduct a research and training program in Radar for the U. S. Army, has returned to this hospital. He is Director of the Psychological Laboratory and will resume his research work in Electro-encephalography, and will teach at Brown University.

* * * * *

Butler Hospital is planning to open an Out Patient Clinic, designed primarily to meet the needs of returning veterans and their families, but also available to others in the community. The Clinic is being financed by Rhode Island corporations and will be opened as soon as money and personnel are available. It is the hope of Dr. Ruggles that the formal opening may be held the latter part of this year or early in 1946.

* * * * *

Mr. Walter Harrington, Assistant Superintendent of the Pawtucket Memorial Hospital, has just returned from Chicago where he attended the 13th Institute for Hospital Administrators.

Memorial Hospital of Pawtucket is making plans to increase its capacity by 58 beds and create more adequate laboratory facilities as a result of its current $500,000 building fund campaign.

When the public campaign was launched last month, a total of $290,951 was announced at the first report meeting. Subscriptions by corporations then amounted to $146,185. Contributions by individuals to establish memorials in the enlarged hospital had reached a total of $142,616. The first returns from the general public accounted for $2150.

Robert R. Jenks, president of the board of trustees, said building will be started as soon as materials and labor are available. J. Colby Lewis is chairman of the building fund.

The enlargement project includes a two-story private wing, a two-story addition in the rear of the present men's orthopedic wing, and the reconstruction of the present private wing. The capacity, upon completion of the expansion program, will be 230 beds.

* * * * *

During the past month the Community Relations Committee of the Woonsocket Hospital circularized the district served by the hospital to find out what the people think of the way in which the hospital has fulfilled its responsibilities to the community and what recommendations can be advanced as to future steps.

The poll of the public includes a questionnaire asking for yes or no answers to ten questions, and also nine questions on which opinions are sought. As no signature is required of the person answering the poll the Committee hopes to secure a sizable number of replies giving frank answers to the queries put forth. The experiment should contribute much to the progressive development of the hospital, and it is to be commended as an excellent example of public relations work.

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(As of October 10, 1945)

(*Indicates member in service with the armed forces of the United States)

(†Indicates Associate Member)

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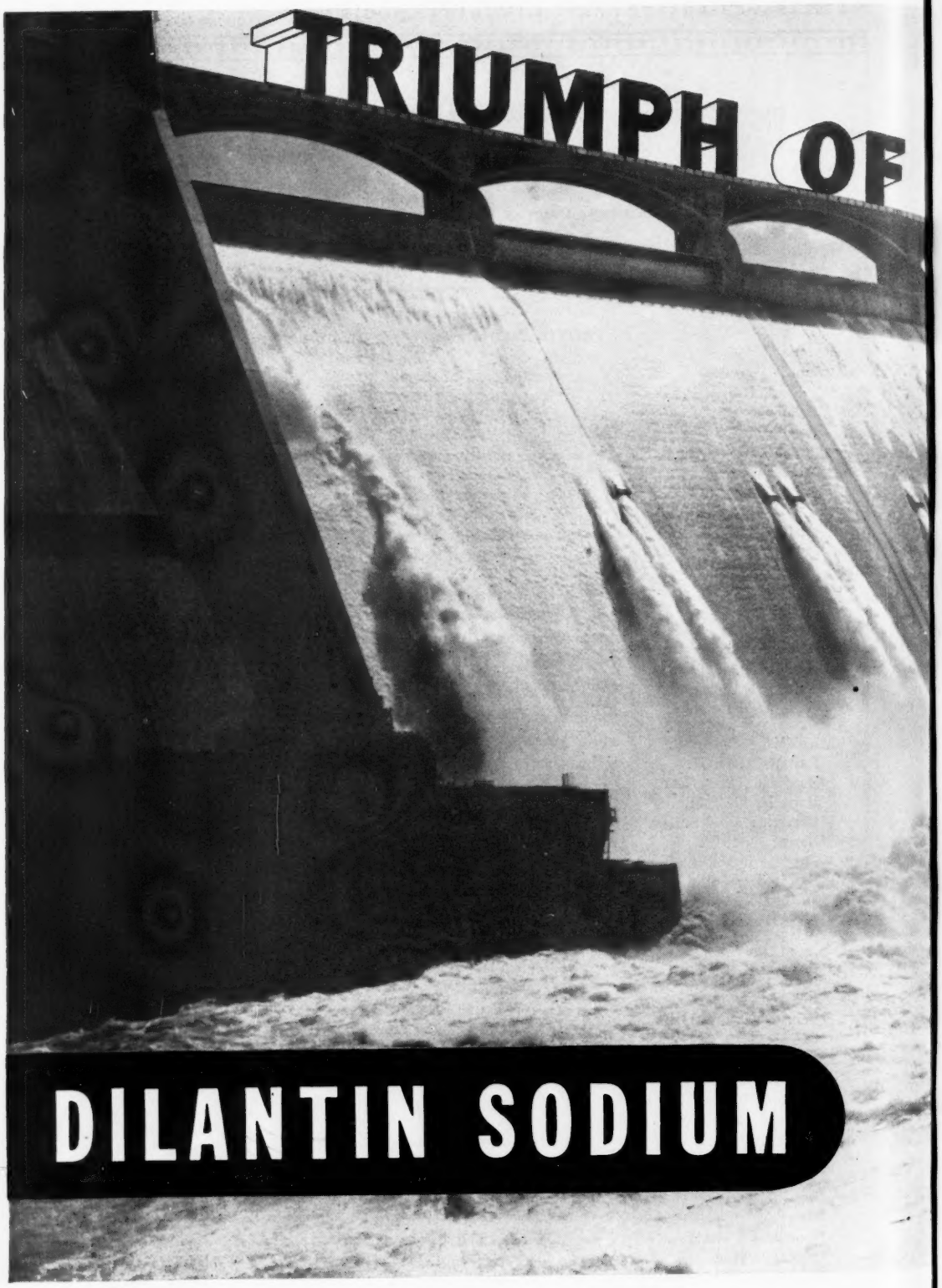
TRIUMPH OF
DILANTIN SODIUM

PROVIDENCE MEDICAL ASSOCIATION

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Troppoli, Daniel V.

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concluded from preceding page

*Trott, Raymond H.
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Turner, Howard K.

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IN COMMON OTOLOGIC

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White's OTOMIDE

Both *acute* and *chronic* suppurative and nonsuppurative infections of the middle and external ear respond to the well-balanced formula of White's Otomide.

FORMULA

Sulfanilamide	5%
Carbamide (urea)	10%
Chlorobutanol (compatible with sulfonamide)	3%
Glycerin (High specific gravity)	q.s.

RATIONALE AND ADVANTAGES

1. *Wide Field*—effective in *BOTH* acute *AND* chronic otologic infections.
2. *Well Tolerated*—physiologic pH—hence free from irritation.
3. *High Stability*—a *stable* sulfonamide-urea solution.
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5. *Hygroscopic*—glycerin vehicle re-distilled for unusual hygroscopic activity.

White's Otomide is available in dropper bottles of one-half fluid ounce (15 cc.)—*on prescription only.*

PHARMACEUTICAL White LABORATORIES, INC. NEWARK 2, N. J. MANUFACTURERS

DOCTORS AT WAR

SURGEON GENERAL ANNOUNCES NEW OFFICER RELEASE POLICY

A REVISED point system program which will return 13,000 physicians, 25,000 nurses, 3,500 dentists and an undetermined number of other Medical Department officers to civilian life by January 1, 1946, was announced September 14, 1945, by Major General Norman T. Kirk, The Surgeon General.

Under the plan those Medical and Dental Corps officers who have 80 points, are 48 years of age or have been in the Army since before Pearl Harbor will be released as surplus officers unless they are specialists in eye, ear, nose and throat work; plastic surgery, orthopedic surgery, neuropsychiatry or are laboratory technicians. These specialists will be released if they were called to active duty prior to January 1, 1941.

This is a drastic lowering of points below the previous plan which was based on an adjusted service score of 100 for non-scarce Medical Corps officers and 120 for those in scarce categories.

A similar drastic reduction was made in the point score for nurses, who are now eligible for discharge if their rating is 35 or more, or if they are 35 years old. In addition all married nurses and those with children under 14 years are eligible for immediate separation. Physical Therapists and Dietitians are eligible under the same conditions if their point score is 40 or more, or if they are 40 years old.

Veterinary Corps officers will be eligible for discharge if they have a point score of 80 or more, if they are 42 years old, or if they joined the Army prior to January 1, 1941.

Medical Administrative and Sanitary Corps officers with point scores of 70 or more, who are 42 years of age or have been in service since before Pearl Harbor will be released as surplus.

General Kirk added that in some cases essential officers may be retained by military necessity until replacements are shifted to their positions but none will be held in service after December 15, 1945, without their consent.

Every effort will be made to release these officers at the earliest possible moment consistent with military needs, General Kirk added.

It is also anticipated that, on the basis of an army of 2,500,000 men, a total of 30,000 doctors, 40,000 nurses and 10,000 dentists will be released by July 1946 and if the armies of occupation and troops in the United States are concentrated at large posts these figures will be exceeded. These figures represent approximately 70 per cent of the peak strengths at VE-Day of these corps.

SURPLUS PROPERTY FOR VETERANS

Under the provisions of the Surplus Property Board regulations preference is granted to veterans who apply for property useful in business or professional enterprises. For the physician-veteran this regulation should prove most helpful in his task of assembling equipment that he will need in re-establishing private medical practice. Consumer goods expected to be available will cover the entire range of commodities such as medical supplies, medical equipment, office furniture, scales, plumbing and lighting fixtures, automobiles, etc. A veteran may purchase up to $2,500 for such goods.

Any physician-veteran desiring to exercise the preference granted him in the purchase of surplus property useful to maintain or establish his professional work must file application with the district office of the Smaller War Plants Corporation (in Rhode Island at 631 Industrial Trust Bldg.,

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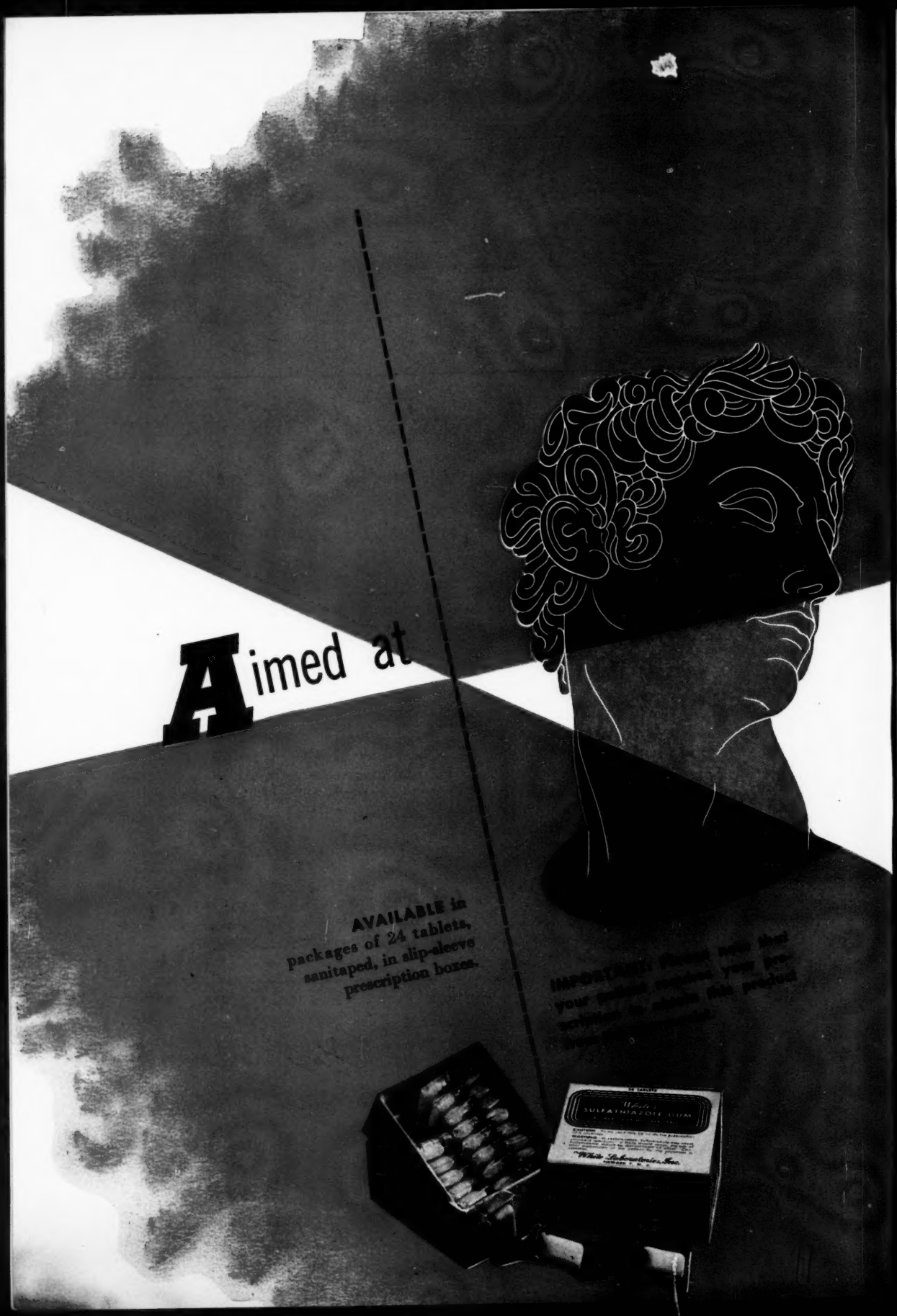
Aimed at
AVAILABLE in
packages of 24 tablets,
sanitaped, in slip-sleeve
prescription boxes.
SULFATHIAZOLE

SURPLUS PROPERTY

continued from page 747

Providence). Such applications receive first priority in that they are in the category of federal agencies which receive an 18 day priority following notice of the availability of a product by the Office of Surplus Property.

One difficulty for the physician-veteran yet to be clarified is that of what constitutes his discharge date from military service. The Surplus Property Office at present holds to the ruling that a doctor, or any veteran for that matter, is discharged when he has used up his surplus time. Since many physicians are returning direct from the battle fronts and have terminal leaves of some duration coming to them prior to release from service, they may face difficulty in acquiring surplus consumer goods on the priority basis during this final leave as they plan for the resumption of practice.

Physician-veterans from Rhode Island may secure complete information and assistance in applying for surplus property through the executive office of the Society.

MILITARY ANNOUNCEMENTS

TRANSFERS

LT. COMDR. FREDERIC W. RIPLEY, JR., MC, Navy Base Hospital, Box 180, Navy 3245 c/o FPO, San Francisco, Calif.

CAPT. JOHN M. MALONE, MC, 0-474102, Church Lane, Portsmouth, Rhode Island.

MAJOR FRANCIS H. CHAFFEE, MC, 12 Humboldt Avenue, Providence, Rhode Island.

CAPT. DONALD L. DENYSE, MC, 0-1696220, Company D, 369 Med. Bn., APO 417, c/o PM, New York, N. Y.

CAPT. JOHN J. DONNELLY, MC, 0-312131, Med. Detch., 259th Engineer Combat Bn., APO 22004, c/o PM, San Francisco, California.

CAPT. IRVING A. BECK, MC, Army General Hospital, Camp Edwards, Massachusetts.

COL. HERMAN A. LAWSON, MC, Torney General Hospital, Palm Springs, California.

MAJOR FRANK J. JACOBSON, MC, 01696217, Station Hospital, Cp. Charborne, Louisiana.

CAPT. CLARENCE J. RILEY, MC, 0-499891, 92nd Station Hospital, APO 610, c/o PM, New York, N. Y.

LT. COMDR. WILLIAM J. SCHWAB, MC, USNR, Div. Aide, APO 217, c/o FPO, San Francisco, California.

MAJOR WALTER S. JONES, 0-464152, 165 Waterman Street, Providence, Rhode Island.

COMDR. HAROLD W. WILLIAMS, U. S. Naval Amphibious Base, Annex 2, Little Creek, Virginia.

LT. COMDR. EDWARD L. SMITH, USNR, G-6, No. 63, Military Government Medical Facilities, APO 331, c/o PM, San Francisco, California.

MAJOR MICHAEL ARCIERO, MC, 16th Arm'd Division, APO 412, c/o PM, New York, N. Y.

COMDR. JAMES P. LONDERGAN, MC, USNR, Newport Naval Hospital, Newport, Rhode Island.

LT. COL. HUGH E. KIENE, MC, 0-469150, 7th U. S. General Hospital, APO 871, c/o PM, New York, N. Y.

CAPT. JOSEPH E. WITTIG, 0310855, 167th Evac. Hosp., APO 248, c/o PM, San Francisco, Calif.

COMDR. JARVIS D. CASE, MC, G. 18, Unit 310, Mil. Gov. Hdq. D4, A.G.F., APO 331, c/o PM, San Francisco, California.

CAPT. C. T. ANGELONE, MC, 0-348671, Regional Hospital, Fort Leonard Wood, Missouri.

CAPT. EDWARD DAMARJIAN, MC, Woodrow Wilson General Hospital, Staunton, Virginia.

LT. COMDR. BANICE FEINBERG, MC, USNR, Fleet Hospital 107, c/o FPO, San Francisco, Calif.

CAPT. RAYMOND H. TROTT, MC, 23rd Station Hosp., ASFTC, c/o Med. Units, Camp Crowder, Missouri.

LT. ROBERT W. RIEMER, MC, 0-925892, 28th Field Hospital, APO 403, c/o PM, New York, N. Y.

LT. JOHN P. HOGAN, MC, USNR, Naval Separation Center, Lido Beach, Long Island, New York.

LT. COL. CLARENCE E. BIRD, MC, 0-214496, 317th Gen. Hosp., APO 957, c/o PM, San Francisco, Calif.

PROMOTIONS

LIEUTENANT JOHN J. DONNELLY to Captain.

LIEUTENANT FREDERICK R. RILEY to Lieutenant Commander.

LIEUTENANT ARTHUR H. VAUGHN to Lieutenant Commander.

LIEUTENANT COMMANDER HAROLD WILLIAMS to Commander.

LIEUTENANT COMMANDER JARVIS D. CASE to Commander.

LIEUTENANT COMMANDER JAMES P. LONDERGAN to Commander.

LIEUTENANT FREDERIC W. RIPLEY to Lieutenant Commander.

LIEUTENANT C. T. ANGELONE to Captain.

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY

Report of Meeting held on September 27, 1945

A MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Thursday, September 27, 1945. The meeting was called to order by President John F. Kenney at 8:20 p. m.

The following delegates were in attendance: Drs. Rocco Abbate, Earl J. Mara, Stanley Sprague, Alex M. Burgess, Harold G. Calder, Earl B. Clarke, G. Edward Crane, Frank W. Dimmitt, Edward V. Famiglietti, A. Henry Fox, Peter F. Harrington, Albert H. Jackvony, Emery M. Porter, Henry E. Utter, George W. Waterman, John F. Kenney, William P. Buffum, Alfred Potter, Charles J. Ashworth.

The President reported relative to the public announcement he had made early in July in criticism of Governor McGrath's address in which he endorsed all but one provision of the Wagner Act at the conference of the governors at Mackinac Island in Michigan. He also reported that he had prepared the article on, "The Doctor's Patient and the Wagner Act" at the request of the *Providence Journal* in order that the public might have a clear understanding of the medical aspects of that legislation. He also reported relative to the formation of the Council of the State Medical Societies of New England at a meeting held in Providence during the summer, and he related briefly the plans for the operation of this new council.

Members of the House discussed the possibility of a wide distribution of reprints of Dr. Kenney's explanation of the Wagner Act, and the Executive Secretary was authorized to explore the possibility of a state-wide distribution that the public might be fully informed.

Treasurer's Report

Dr. Charles J. Ashworth, Treasurer, reported that he had found a contradiction in the By-laws relative to the authorized date for submission of the budget of the Society, and he asked for clarification by the House on this matter, noting that a suggested amendment was being submitted by the Council for possible action. He also reported that the anticipated budget for 1946 would require an annual dues assessment which would not be divided as dues and special tax as in the past, of $25 per member, and he stated that he had submitted his recommendations to the Council on these matters.

The President announced that in accordance with the instructions in the By-laws he should appoint in September a member to the Board of Trustees, and he was therefore reappointing Dr. Robert T. Henry to serve for the year 1946.

1946 Annual Meeting

The President announced that the officers of the Society have recommended that the Annual Meeting be held in 1946 on Wednesday, May 15 and Thursday, May 16, at Providence, and that the Council had approved these dates. Dr. Emery Porter moved that the House approve of the dates recommended for the Annual Meeting. The motion was seconded and passed.

By-Law Amendments

Dr. William P. Buffum, Secretary, reported for the Council. He read and explained the changes recommended in the By-laws to provide for the reorganization of the membership of the Standing Committees and also for the establishment of new Standing Committees on Post-graduate Education and on Public Policy and Relations. The recommended changes were discussed by the Members of the House, and Dr. Charles J. Ashworth moved that the section relative to the election of Members-at-Large be amended further to read that these three Members-at-Large to be elected by the House shall be Fellows of the Society "who are members of the Providence Medical Association." The motion was seconded and adopted.

The Secretary also submitted the recommended change in the By-laws for clarification; the apparent contradiction relative to the time at which the Secretary should submit the annual budget of the Society to the Council.

Dr. Harold Calder moved that the House of Delegates approve the changes and the amendments to the By-laws as proposed. The motion was seconded and passed.

Annual Dues for 1946

The Secretary reported that the Council recommends that the annual dues for each active Member for 1946 shall be $25. The House moved the

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adoption of this fee for the annual assessment. The motion was seconded and passed.

Committee on Public Policy

The President called for any reports or recommendations by any delegates from their district societies. Dr. Emery M. Porter reported that the Executive Committee of the Providence Medical Association had recommended Dr. Duncan J. Bell of Providence as a representative on the Committee on Public Policy and Relations to be appointed by the President.

The President announced that it was his desire following the approval by the Council at its June meeting to establish as soon as possible a Committee on Public Policy and Relations. He noted that the action of the House of Delegates now authorized the election of such a committee in 1946 if the amendments proposed are accepted by the membership at the next general meeting. In the interim he expressed the desire to have the Public Relations Committee work on various phases of the new program proposed. Therefore, he asked that the House nominate members whom he might appoint to the committee.

The attention of the House was called to the fact that the appointment at this time of the new Public Relations committee would necessarily absorb the work now being carried on by the Committee on Medical Education. It was moved, therefore, that it be the sense of the House of Delegates that the Members of the Committee on Medical Education who have worked long and hard at their task of public information through the radio programs should be excused from the task in order that a larger and more representative state-wide committee may expand the entire program of public relations and information. The motion was seconded and passed.

In addition to the nomination of Dr. Bell submitted by the Executive Committee of the Providence Medical Association, the following Fellows were recommended to the President for possible appointment to the new committee: Dr. Charles Bradley, Dr. Joseph Belliotti, and Dr. Guy Wells.

Committee on Postgraduate Education

The President called for reports of the committees. Dr. Alex M. Burgess, Chairman of the Committetee on University, Hospital, and Medical Society Relations, reported as follows:

"Your committee begs leave to report the following activities:

1. *Institute of Pathology*

The committee has continued its study of the question of establishing an institute of pathol-

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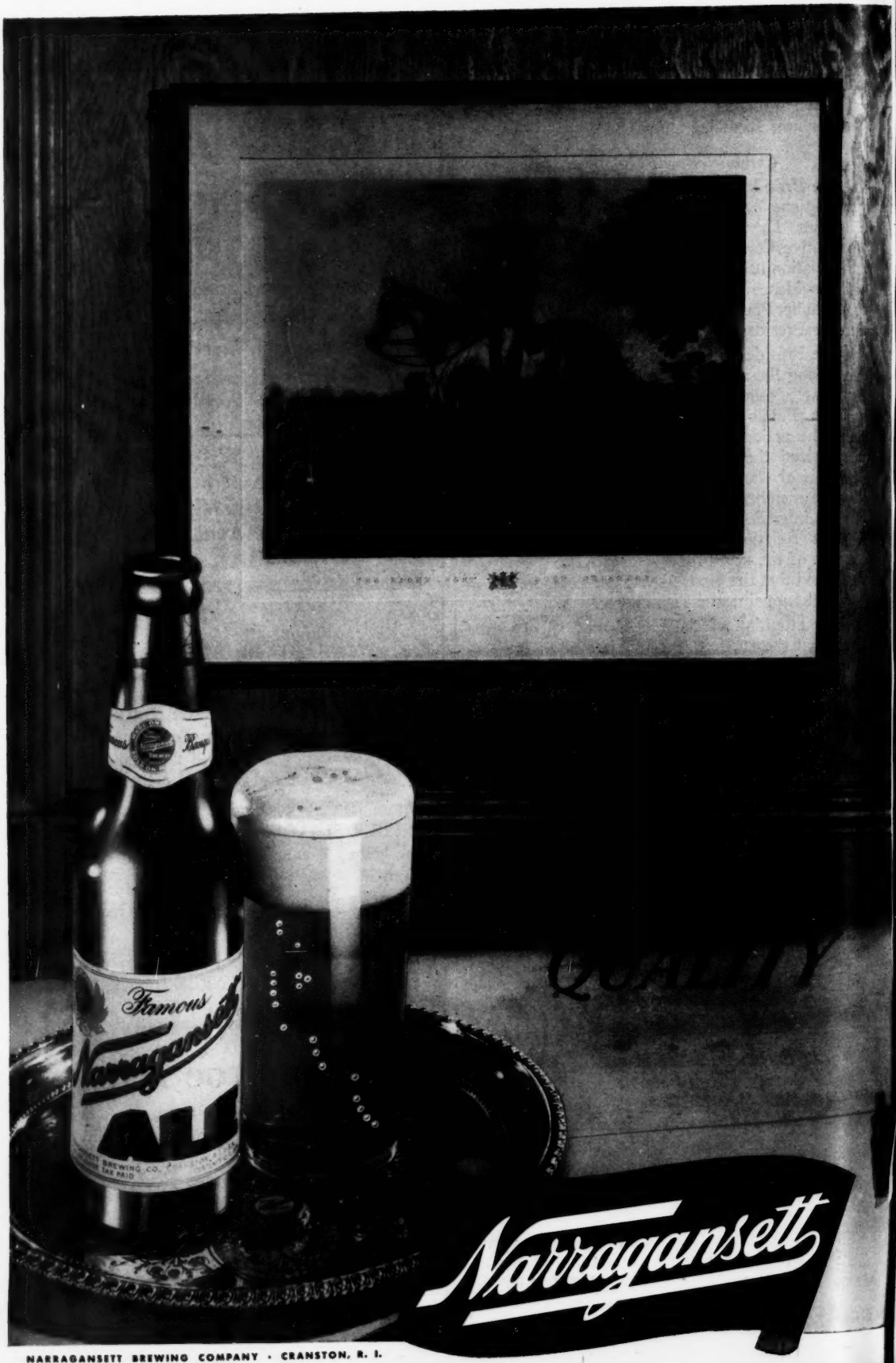

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HOUSE OF DELEGATES

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ogy to serve all the hospitals of the state which wish to avail themselves of this service. Although a considerable amount of work in this project has been done there are no results ready for a report at this time.

2. *Post-War Education of Physician Veterans*

99 answers to questionnaires were received. Of these 29 men stated that they did not desire further training.

Of the 70 who expressed a desire for further training 20 requested residencies and 50 refresher courses in various subjects, the largest number in medicine and surgery. As none of the hospitals has completed its plans for post-war training of medical veterans it has not yet been possible to complete arrangements for any of these men except two. One man has obtained post-graduate training in cardiology and another has received the award of a fellowship in internal medicine through the efforts of the committee.

As the majority of these physicians wish their training in Rhode Island it is necessary for the committee to determine what facilities will be available. Information on this subject is being obtained as rapidly as possible but for the most part the plans of the hospitals and colleges are not yet fully developed.

3. *The Establishment of a Service Bureau*

The committee has approved, and hereby suggests to the House of Delegates the establishment of a Service Bureau for returned medical officers similar to that which has been established in Connecticut. Such a Bureau should collect and have available for the benefit of these officers information of interest to them. Such information should include not only educational opportunities but also lists of locations needing physicians, available office space, opportunities for employment in industry, public service and the like. Such a Service Bureau could be conducted by the executive office but would require the employment of one or more secretaries to operate it. This committee believes that it should work with such a Bureau in the matter of educational opportunities."

Veterans' Service Bureau

Dr. Burgess stressed the need for the establishment of a Service Bureau as noted in the report of his Committee. He pointed out the importance of the service to the returning physicians. The Executive Secretary commented on the data he is accumulating at his office to be made available to doctors returning from the armed forces. Dr. Albert H. Jackvony, Chairman of the War Veterans Committee of the Providence Medical Association, related the activities of his Committee and in particular reported on the possibility of physicians who are veterans acquiring surplus property to establish themselves in private practice. Dr. Peter F. Harrington related that he had heard that diagnostic centers were to be set up about the country and were to be equipped with surplus medical supplies furnished by the Government. He queried as to whether the House was aware of any possible movement and asked who would control the medical service to be rendered.

Dr. Emery M. Porter moved that the Society should establish a Service Bureau at the Executive Office to aid the Rhode Island doctors returning from the armed forces and that the Executive Secretary should be authorized to secure paid secretarial aid as needed to carry out the purpose of this bureau. The motion was seconded and passed.

Committee on Social Welfare

Dr. Peter F. Harrington, Chairman of the Committee on Social Welfare reported as follows:

"At the last meeting of the House of Delegates it was requested that the Committee on Social Welfare formally submit a report. During the past year several meetings have been held by the Committee and the Division of Public Assistance.

continued on page 762

Sulfathiazole on the infected epipharynx of patient T. D., one hour after the Suspension had been instilled.

PAREDRINE-SULFATHIAZOLE SUSPENSION

Vasoconstriction in minutes—

Bacteriostasis for hours

For prolonged Bacteriostasis in Nasal and Sinus Infections

. . . When Paredrine-Sulfathiazole Suspension is instilled into the nose on retiring, the Micraform (microcrystalline) sulfathiazole can often be observed on *infected* mucosa the next morning—conclusive evidence that bacteriostasis has persisted all night long.

The fundamental reason for the striking success of Paredrine-Sulfathiazole Suspension is the fact that it is not a solution, but a suspension of micro crystals of free sulfathiazole. Unlike solutions of sodium sulfathiazole, the Suspension does not quickly wash away. It remains on those areas where ciliary action is impaired by infection—and thus provides prolonged bacteriostasis precisely where it is needed most.

In addition to this outstanding advantage, Paredrine-Sulfathiazole Suspension—whose pH range is slightly acid, 5.5 to 6.5—does not irritate or sting, and it does not produce such central nervous side effects as insomnia, restlessness and nervousness.

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HOUSE OF DELEGATES

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The important matters which were discussed and which are now submitted for your consideration are herewith presented.

1. The Department of Social Welfare feels it is desirable to have a standard fee schedule to cover all types and forms of medical examination and treatment.

The fee schedule for payment to doctors for care given to recipients of public assistance varies considerably throughout the state. The Committee feels this is a matter for the House of Delegates to decide.

2. The Department of Social Welfare admitting the superior knowledge of Specialists and designating a higher fee for their examination and treatment of a patient, would like to know whom the Rhode Island Medical Society considers to be Specialists in the various branches of medicine.

The Committee is in no way capable of deciding who would fall into the category of Specialists in any particular field of medicine. Some clarification of this whole matter is highly desirable in the near future in as much as it may be of some bearing on the medical treatment to be given to returning veterans as well as to the recipients of the relief program.

3. The Department of Social Welfare wishes the approval of the Medical Society for the plan in operation in East Providence and Warren.

The Committee does not feel that sufficient experimentation has been completed to evaluate the form of payment which the Division of Public Assistance contemplates putting into effect throughout the state. Many war time factors have influenced the distribution and cost of medical care in the past few years and it was under such conditions that the experiments were conducted. The results are probably not a true picture of what a long range program would show.

4. Considerable discussion was held concerning the use of Osteopaths and Optometrists in the treatment of clients for the Division of Public Assistance.

This in part was somewhat solved to the satisfaction of the Department of Public Assistance by state law, which in effect forbids the Department of Social Welfare from discriminating against Osteopaths. A clarification of the limitations in eye examination by Optometrists would be helpful to the Department."

Listing of Specialists

Dr. Harrington asked for action by the House of Delegates on the various matters submitted in his report. There was a long discussion regarding the question of rating specialists in Rhode Island. Dr. Alfred Potter moved that the Committee on University, Hospital and Medical Society Relations, which is henceforth to be known as the Committee on Postgraduate Education, should form a plan for the listing of physicians throughout the state who in their opinion may be recognized as specialists in the various phases of medicine. The motion was seconded and passed.

Fee Schedules

Dr. Rocco Abbate raised the question relative to a uniform fee schedule for office and home visits throughout the state, and he pointed out that the Pawtucket Medical Association and the Kent County Medical Society have similar schedules at the present time, but that the Providence Medical Association has never taken any action towards adjusting its fees for house and office visits in spite of the increased costs of professional service as well as costs in general. The problem was discussed briefly and it was the sentiment of the House that it was a question that should be referred to the Providence Medical Association for its action.

Examinations by Optometrists

The question of clarification of the limitations in eye examinations by optometrists was discussed at length. It was the sense of the House that there should be limitations for optometrists beyond which they should be required to refer patients to the opthalmologists. Dr. Kenney announced that he would appoint a group of opthalmologists to study and report back to the House of Delegates on this matter.

Medical Needs of Veterans

The question of the medical needs of the returning veterans was reviewed at length. A report in writing relative to a conference on this question held in Connecticut was submitted by the Executive Secretary and he also reported his meetings with the head of the Veterans' Administration in Rhode Island. Dr. Peter F. Harfington reviewed the work of the medical phases of the Retraining and Rehabilitation Committee established by the Government and he reported that the psychiatric clinic requested by the Committee had been put into operation at the Chapin Hospital.

Dr. Alex M. Burgess moved that the House of Delegates go on record stating its position as regards the question of medical care for returning veterans and a statement submitted was read to the House. The statement was amended by action of the House and it was then moved that the entire statement be publicized by the President in such a manner as he shall consider best.

The statement adopted was as follows:

"The Council and the House of Delegates of the Rhode Island Medical Society have carefully

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HOUSE OF DELEGATES

concluded from page 762

studied the question of the current medical needs of the veterans of World War II and wish to record the following:

"The medical profession of Rhode Island, depleted by almost one third of the active practitioners by the demands of the Army and the Navy, has carried on the task of caring for the civilian population throughout the war period effectively in spite of the tremendous physical strain involved.

"The sudden ending of the war and the subsequent return of thousands of discharged members of the armed forces, while at the same time very few physicians have been returned to Rhode Island to resume civilian practice, has created problems for the Veterans' Administration in the matter of physical examination of veterans for claims and pensions.

"In spite of the limited civilian medical personnel and the limited hospital facilities in the state, the Rhode Island Medical Society is certain that its membership will assist the Veterans' Administration in meeting the medical needs of Rhode Island veterans in so far as possible. The Society has participated very actively for more than a year in organizing the medical phases of the program of the Veterans' Retraining and Rehabilitation Committee appointed by Governor McGrath, and it has put into operation psychiatric clinics as suggested by that committee.

"The Society, however, does re-affirm its belief that the medical care of the civilian population of which the veterans are now a part, is paramount, and must have first claim upon the time and energies of the physicians of this state. The failure of the Veterans' Administration to staff adequately its service to meet the demands it should have anticipated with the end of the war, in Asia as well as in Europe, is unfortunate.

"The Rhode Island Medical Society believes that its members will most willingly give of their available time to any veteran in need of medical attention for his physical well being, and will assist him in his claim for a pension as a secondary consideration in the overall problem of distributing medical service for emergency and civilian care until such time as sizable numbers of the Rhode Island physicians retained by the armed forces are returned home."

There being no further business the President moved the adjournment of the House of Delegates

The House was adjourned at 10:20 p. m.

Respectively submitted,

WILLIAM P. BUFFUM, M.D., *Secretary*

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC., REQUIRED BY THE ACTS OF CONGRESS OF AUGUST 24, 1912, AND MARCH 3, 1933

of *Rhode Island Medical Journal,* published monthly at Providence, Rhode Island, for October, 1945.

State of Rhode Island } ss.
County of Providence }

Before me, a Notary Public in and for the State and county aforesaid, personally appeared Peter Pineo Chase, M.D., who, having been duly sworn according to law, deposes and says that he is the Editor-in-Chief of the *Rhode Island Medical Journal* and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, as amended by the Act of March 3, 1933, embodied in section 537, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are: Publisher, Rhode Island Medical Society, 106 Francis Street, Providence, R. I.; Editor, Peter Pineo Chase, M.D., 106 Francis Street; Managing Editor, John E. Farrell, 106 Francis Street, Providence, R. I.

2. That the owner is Rhode Island Medical Society, 106 Francis Street.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

PETER PINEO CHASE, M.D., *Editor-in-Chief*

Sworn to and subscribed before me this 18th day of September, 1945.

JOHN E. FARRELL, *Managing Editor*

(My commission expires June 30, 1946

[SEAL.]

THROUGH ...  *the Microscope*

The United States of America Typhus Commission Medal for "exceptionally meritorious service" has been awarded to Dr. Francis G. Blake, Dean of Yale Medical School, who was the Charles V. Chapin orator at our annual meeting in Providence last May . . . Dr. Blake was cited for "new contributions to the knowledge and control of a form of typhus fever of great military and civilian importance. * * * The Public Administration Clearing House reported recently that employees of the city of Detroit had voted nearly 5 to 1 in favor of a $500,000 hospital and death benefit insurance plan proposed by the mayor. A mandatory death benefit (life insurance) of $2,000 for each employee, costing $26 a year of which the city would pay half, and an optional hospitalization contract with a private company costing $17.68 a year (to be shared equally by the city and employee) is proposed. Whether tax funds can be used for a death benefit plan which would accrue to the interest of someone other than the employee poses a legal barrier that may disrupt the proposal * * * Dr. Dudley A. Reekie, Minnesota physician who became acquainted with many New England physicians during his service as medical director of Civilian Defense in this area three years ago, is now on leave from the USPHS to work with the United Nations Relief and Rehabilitation Administration, and according to our last report he is commanding medical officer of the UNRRA mission in Italy * * * With the question of public health education coming increasingly to the fore the committee on Professional Education of the American Public Health Association, of which Dr. William P. Shepard is chairman, is undertaking a program for the accreditation of schools of public health. * * * Federal authorities finally awakened to the seriousness of the shortage of doctors and dentists to supply the anticipated needs in the years ahead, and as a step towards remedying the situation plans have been initiated to encourage the enrollment of 12,000 students for medical, dental, pre-medical and pre-dental school courses beginning this fall from among veterans being discharged from the armed forces . . . The question is whether the intensive educational program necessary for the completion of such courses will appeal to the veteran who has been removed from academic routine for some time. * * * Dr. Wallace Graham, of Kansas City, sharp critic of the closed hospital program, has been reported as being appointed private physician to President Truman. * * * As of the end of last June approximately 5,100 plastic artificial eyes have been made and fitted under the Army Medical Department's supervision at plastic eye centers. * * * The federal community school lunch program in Rhode Island has shown steady growth since its inception in the Spring of 1943. In June of that year 43 schools participated. In June of the present year 183 schools were given assistance, with about 20,000 students participating. * * * Recent Army announcements report that Cushing General Hospital has been approved for the professional refresher training of Medical Corps officers to extend over a 12 week period, and that a center specializing in the treatment of tropical skin disease will be established at the Army general hospital at Camp Edwards. * * * The Metropolitan Life Insurance reports in its Statistical Bulletin that "within the brief period of three years, from 1940 to 1943, maternal mortality in the United States fell by more than one third, to a level of 21 per 10,000 live births for the white population, and to 51 per 10,000 for the colored." Studies by the company indicate that the mortality is lowest where hospital confinement is most frequent. * * * Army technical units sponsored and manned by civilian institutions such as hospitals, will not be discontinued now that the war has ended, the War Department has announced. They will be continued in an inactive reserve status as part of the postwar military establishment. * * *

SENATOR GREEN'S SOCIAL SECURITY BILL

(Reprinted from *Insurance Economics Surveys*, Vol. 2, No. 2, August, 1945, by the Insurance Economic Society of America.)

S. 1188, titled "Social Security Amendments of 1945" was introduced June 25, 1945, by Senator Green, Rhode Island, with not a little accompanying publicity, though less than that resulting from the introduction of the 1945 Wagner-Murray-Dingell bill. The Senator points out that his bill is limited "to those modifications and additions on which I think there may be fairly ready agreement."

The measure provides for increases in several phases of the public assistance program set-up under the Social Security Act and its amendments, and for certain extensions of the compulsory social insurance system of the Act — as follows:

1. OLD AGE AND SURVIVORS' BENEFITS
   - A) Retirement age for females adjusted to age 60.
   - B) *Disability:* provision for retirement after 6 months disability, ages 18 to 65.
   - C) Minor adjustments in regulations as to various types of survivor benefits.
   - D) *Lump sum death benefits* provided for at rate of 6 times primary benefit.
   - E) *Coverage extended* to about 15,000,000 additional persons, including farmers and farm labor, domestics, self-employed, etc.
2. MILITARY SERVICE BENEFITS
   - A) Credits of $160 to $250 a month for military service.
3. FEDERAL HOSPITALIZATION BENEFITS
   - A) Provides for hospitalization benefits for currently insured individuals, for wives and children of such individuals, and for other dependents as well as persons benefiting through public assistance but not entitled to hospitalization thereunder.
   - B) A maximum of 30 days hospitalization per year is allowed (possibly 60 days if funds are adequate). Hospital bills might be paid directly or an allowance made to the claimant of not less than $3 per day nor more than $6.
   - C) One fourth of taxes collected under the bill would be allocated to the Federal Hospitalization Benefits Account, a separate account within the Trust Fund.
4. TAXATION
   - A) Employee — *2%* up to $3,000 of wages.
   - B) Employer — *2%* up to $3,000 of wages paid.
   - C) Self-Employed — 4% up to $3,000 of value of services.
5. UNEMPLOYMENT COMPENSATION
   - A) Amends administrative procedure.
   - B) *Temporary disability* resulting in inability to carry on regular work would be compensable on the same basis as other causes of involuntary unemployment.
   - C) Provides for a federal subsidy to approved states equal to one-half the amount of approved claims.
   - D) Revises Internal Revenue Code to provide for premiums from employers and employees, as follows:
     Employer — ½% of wages paid.
     Employee — ½% of wages received.